

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

12653

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STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 17 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital		d. STREET ADDRESS 141 Second Street	
3. NAME OF DECEASED (Type or print) Sarah Ruth Davis		4. DATE OF DEATH Month November Day 22 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1879 March 30, 1889
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 22 Days 19 Hours 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Wilburn, Ralph Thayer		14. MOTHER'S MAIDEN NAME Hall, Marjorie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. W. H. Davis	
17. INFORMANT W. H. Davis		Address Oakland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Pneumonia Terminal DUE TO (b) Cerebral Hemorrhage DUE TO (c) Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus Fracture R. Hip		INTERVAL BETWEEN ONSET AND DEATH 2 Days 14 Days 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 1961 to 22 Nov 1961 , that (I) (we) last saw the deceased alive on 22 Nov 1961 , and that death occurred at 2:50 A.M. from the causes and on the date stated above.		22b. DATE SIGNED 22 Nov 61	
22a. SIGNATURE A. E. Mance M.D. 22c. PHYSICIAN'S NAME (Type) Dr. A. E. Mance		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/24/1961	
23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		23d. LOCATION (City, town or county) (State) Oakland, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		25a. REC'D BY REGISTRAR DATE NOV 27 '61	
ADDRESS Oakland, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	



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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12654

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12641

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 8 HRS.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DEER PARK, MD.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ORLAND		First Middle Last DUNHAM		4. DATE OF DEATH Month NOVEMBER Day 14 Year 19 61			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 5, 1884	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Dunham George				14. MOTHER'S MAIDEN NAME Laura Collins			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 218-12-5747		17. INFORMANT W. E. Dunham, Friendsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 4221 DUE TO Arteriosclerosis, generalized (b) DUE TO Myocardial insufficiency (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 48 hrs. Years Years	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) OAKLAND, MARYLAND							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		M.D. DR. JAMES H. FEASTER, JR.		DATE SIGNED 11-14-61			
EXAMINER'S NAME (Type) DR. JAMES H. FEASTER, JR.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-17-61		22c. NAME OF CEMETERY OR CREMATORY Steele	
22d. LOCATION (City, town, or country) (State) Friendsville, Garrett, Md.		23. FUNERAL DIRECTOR Don Newman		ADDRESS Grantsville, Md.		24a. REC'D BY REGISTRAR NOV 20 '61	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>							

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(1)

Laborer

George W. Duggan

George

John Collins

218-12-077 H. W. Duggan, Knoxville, Mo.

Acute pulmonary edema

arteriosclerosis, generalized

essential hypertension

Mr. George W. Duggan, Jr.

218-12-077-81

Knoxville, Mo.

Knoxville, Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
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VR A15 (4)
ISM 9/59

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12655
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12642

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY Preston	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland		c. LENGTH OF STAY IN 1b 4 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Newburg 11X-1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Earl Middle Dorcy Last Evans		4. DATE OF DEATH Month Nov. Day 24 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/9/1882
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 7 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal	
11. BIRTHPLACE (State or foreign country) Taylor Co., W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Adolphus Evans		14. MOTHER'S MAIDEN NAME Margaret McCartney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 232-10-6938	
17. INFORMANT Mrs. Geraldine Criss		Address Newburgh, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia terminal 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c) 10 yrs		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1961 to Nov 1961 , that (I) (we) last saw the deceased alive on 23 Nov 1961 , and that death occurred at PM , from the causes and on the date stated above.			
22a. SIGNATURE Andrew E. Mance		22b. DATE 11/24/61	
22c. PHYSICIAN'S NAME (Type) Andrew E. Mance		22d. ADDRESS 3 rd St. Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/27/61	
23c. NAME OF CEMETERY OR CREMATORY Evansville Cemetery		23d. LOCATION (City, town, or county) (State) Preston Co., West Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Gerald M. Minnick		25a. REC'D BY REGISTRAR NOV 28 '61	
ADDRESS Oakland, Maryland		25b. REGISTRAR'S SIGNATURE Charles E. Hance	

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FOR STATE
HEALTH DEPT.
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TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the County Health Officer should execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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12656
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
12643

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakland c. LENGTH OF STAY IN b 17 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Garrett Co. Mem. Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE W.va. b. COUNTY Preston c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Horseshoe Run, W.Va. d. STREET ADDRESS 8 5X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Hervey Francis Evans			4. DATE OF DEATH Nov. 6th. 19 61		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1876		9. AGE (In years last birthday) 85 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY W.Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Warner Evans			14. MOTHER'S MAIDEN NAME Elizebeth Shaffer		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Homer Evans Davis, W.Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, lobar, bilateral DUE TO Conditions, if any, which gave rise to immediate cause (b) Pneumococcus organism DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH days
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10-7-61 EXAMINER'S SIGNATURE James H. Feaster, Jr., M.D. EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D. Address (Street, city, town, or county) Oak., Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/9/61		22c. NAME OF CEMETERY OR CREMATORY Texas 22d. LOCATION (City, town, or country) Horseshoe Run W.Va.	
23. FUNERAL DIRECTOR Wayne C. Spiggle		ADDRESS Davis, W.Va.		24a. REC'D BY REGISTRAR DATE NOV 9 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



12055

12055

Evans

W. Va.

Horsehoe Run, W. Va.

32

May 27, 1976

USA

W. Va.

Partner

Elizabeth Bunker

Warner Evans

Davis, W. Va.

Home Evans

Buried in oval

Davis, W. Va.

Horsehoe Run

W. Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12657

12644

1. PLACE OF DEATH e. COUNTY GARRETT MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 1 mo.-27 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First CHARLES Middle LAFAYETTE Last LEWIS			4. DATE OF DEATH Month NOVEMBER Day 11 Year 1961		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 24, 1885		9. AGE (In years last birthday) 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINER (RET.)		10b. KIND OF BUSINESS OR INDUSTRY COAL	11. BIRTHPLACE (County & State, or foreign country) Maryland, TENNESSEE		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM LEWIS			14. MOTHER'S MAIDEN NAME SUSAN BRAKE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no (If yes give year or dates of service)			16. SOCIAL SECURITY NO. 232-03-1383		
17. INFORMANT WIFE- MRS. CHARLES LEWIS-			Address MT. LAKE PARK, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bunches pneumonia 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Bronchitis (a), stating the underlying cause last. DUE TO (c) arterio sclerosis					INTERVAL BETWEEN ONSET AND DEATH 2 wks - 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 yrs					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JAN. 5, 1961 , to NOV. 11, 1961 , that (I) (we) last saw the deceased alive on NOV. 11, 1961 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Andrew E. Mance M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/16/61
22c. PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.			22d. ADDRESS THIRD STREET OAKLAND, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL, SPECIFY		23b. DATE THEREOF 11/14/1961	23c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cemetery, near Mt. Lake Park, Md.		23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE A.C. Leighton			ADDRESS Oakland, Md.		25a. REC'D BY REGISTRAR DATE NOV 16 '61
			25b. REGISTRAR'S SIGNATURE Arthur S. Hance		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland, c. LENGTH OF STAY IN 1b 4 Weeks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Oak Rest Nursing Home						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) West Virginia b. COUNTY Mineral c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elk Garden d. STREET ADDRESS 85X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Etta First Likens Middle Last			4. DATE OF DEATH November 12, 19 61 Month Day Year								
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 26, 1876		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William B. Baker				14. MOTHER'S MAIDEN NAME Naomi Kitzmiller							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. ---		17. INFORMANT (Husband) John T. Likens		Address Elk Garden, W. Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebrovascular hemorrhage DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 wks 10 yrs										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/8/19 60 to 11/12/19 61, that (I) (we) last saw the deceased alive on 19 61, and that death occurred at 6:40A.M. from the causes and on the date stated above.											
22a. SIGNATURE Andrew E. Mance M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 13/11/61			
22c. PHYSICIAN'S NAME (Type) Andrew E. Mance, M.D.						22d. ADDRESS Oakland, Maryland.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/14/1961		23c. NAME OF CEMETERY OR CREMATORY Kalbaugh Cemetery				23d. LOCATION (City, town or county) (State) Elk Garden, W. Va.			
24. FUNERAL DIRECTOR'S SIGNATURE Mildred Sharpless				Oakland, Md. Blaine, W. Va.				25a. REC'D BY REGISTRAR DATE NOV 16 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12659

12647

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park, c. LENGTH OF STAY IN 1b 20 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park, d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle McDermott Last Murray		4. DATE OF DEATH Month November Day 12, Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1872
9. AGE (In years lost birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 12 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY building	
11. BIRTHPLACE (State or foreign country) Ontario, Canada.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Murray		14. MOTHER'S MAIDEN NAME Catherine McDermott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT (Wife) Ella Murray		Address Mt. Lake Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 12 hrs 10 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/1/ 19 46 to 11/12/ 19 61 that (I) (we) last saw the deceased alive on 11/12/ 19 61 , and that death occurred at 6:30 p. M. from the causes and on the date stated above.			
22a. SIGNATURE Andrew E. Mance		22b. DATE SIGNED 11/13/1961	
22c. PHYSICIAN'S NAME (Type) Andrew E. Mance, M.D.		22d. ADDRESS Oakland, Maryland.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/15/1961	
23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		23d. LOCATION (City, town, or county) (State) Oakland, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE A. E. Leighton		25a. REC'D BY REGISTRAR NOV 16 '61	
ADDRESS Oakland, Md.		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	

1904

CERTIFICATE OF DEATH

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MASSACHUSETTS DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,2 & 22a, Film G301 11/24/61 iwk

12660

CERTIFICATE OF DEATH

Reg. Dist. No. 12648

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.D. Grantsville			c. LENGTH OF STAY IN 1b 34 yrs		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County R.D.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Ray Middle Nicklow Last Nicklow			4. DATE OF DEATH Month November Day 14 Year 1961		
5. SEX M	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 9, 1891	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min. 70
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (State or foreign country) Addison, Penna	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Edward Nicklow			
14. MOTHER'S MAIDEN NAME Susan Umberson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 192-12-3427		17. INFORMANT Reba Jane Nicklow Address Garrett County Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 450.0 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Ht Disease DUE TO Parkinson's Disease (c) Parkinson's Disease					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from July , 19 59 , to Nov 12 , 19 61 , that I last saw the deceased alive on Nov 12 , 19 61 , and that death occurred at 1 AM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Harold O. Kamons		M.D. R.D. Markleburg, Pa Nov 15		DATE SIGNED	
PHYSICIAN'S NAME (Type) HAROLD O. KAMONS					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-16-61	22c. NAME OF CEMETERY OR CREMATORY Addison Cemetery	22d. LOCATION (City, town, or county) (State) Addison, Somerset, Pa.		
23. FUNERAL DIRECTOR'S SIGNATURE Don Newman Grantsville, Md		24a. REC'D BY REGISTRAR NOV 17 '61	24b. REGISTRAR'S SIGNATURE William E. Hume		

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12661

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12649

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland. b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland,				c. LENGTH OF STAY IN 1b 8 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4 Mi. S. Oakland, Md.				d. STREET ADDRESS 4 Mi. So. Oakland, /			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Lydia Middle G. Last Petersheim		4. DATE OF DEATH Month November Day 2, Year 19 61					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1877	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Urias Yoder				14. MOTHER'S MAIDEN NAME Katie Brenneman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no.		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Jonas Petersheim R. D. Oakland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) CARCINOMA OF STOMACH DUE TO (c) ARTERIOSCLEROSIS						INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 12 MO. 10 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/1/ 19 53 to 11/2/ 19 61 that (I) (we) last saw the deceased alive on 11/1/ 19 61 , and that death occurred at 10:00P. M. from the causes and on the date stated above.							
22a. SIGNATURE Andrew E. Mance				22b. DATE SIGNED 11/3/1961			
22c. PHYSICIAN'S NAME (Type) Andrew E. Mance, M.D.				22d. ADDRESS Oakland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/6/1961		23c. NAME OF CEMETERY OR CREMATORY Niverton Cemetery		23d. LOCATION (City, town, or county) (State) Somerset County, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE H.C. Leighlon				ADDRESS Oakland, Md.		25a. REC'D BY REGISTRAR DATE NOV 7 '61	
				25b. REGISTRAR'S SIGNATURE Andrew E. Mance			

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13661

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G302 12/7/61 iwk

12662

CERTIFICATE OF DEATH

Reg. Dist. No. 12650

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Good-Will Menonite Nursing Home		d. STREET ADDRESS Main Street	
3. NAME OF DECEASED (Type or print) First ALEXANDER Middle SMYTH Last SMYTH		4. DATE OF DEATH Month 11 Day 28th Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-61 1890
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 71 Days 28 Hours 19 Min.	11. IF UNDER 24 HRS. Months 71 Days 28 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) State Road Commission		10b. KIND OF BUSINESS OR INDUSTRY Frostburg	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander Smyth, Sr.		14. MOTHER'S MAIDEN NAME Elizabeth Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-12-8012	
17. INFORMANT Mrs. Harold Lancaster		Address Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 12 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral Emphysema		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUG 9 , 19 61 , to NOV 27 , 19 61 , that I last saw the deceased alive on NOV 27 , 19 61 , and that death occurred at 8A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE B H HOKE JR		ADDRESS (Street, city or town, state) SALISBURY PA	
PHYSICIAN'S NAME (Type) B H HOKE JR M D		DATE SIGNED 28 NOV 61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-1-61	
22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home		24a. REC'D BY REGISTRAR DEC 4 '61	
24b. REGISTRAR'S SIGNATURE Charles H. Whiteside		24c. REGISTRAR'S SIGNATURE Charles H. Whiteside	

1820

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12663

CERTIFICATE OF DEATH

12651

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY Garrett MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL- GORMAN LENGTH OF STAY (In this place) 2 yrs.				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Garrett CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL- GORMAN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wilson*Corona Road				STREET ADDRESS (If rural give location) Wilson Corona Road			
3. NAME OF DECEASED (First) (Middle) (Last) James Edward Soult				4. DATE OF DEATH (Month) (Day) (Year) Nov. 19, 1961			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Aug. 12, 1946	9. AGE last birthday 15 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY 9th Grade		11. BIRTHPLACE (State or foreign country) Kitzmiller, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wayne Arthur Soult				14. MOTHER'S MAIDEN NAME Thelma Irene DeWalt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Wayne A. Soult, R.D. Gorman, W. Va.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Acute Myocardial Infarction						3 days	
ANTECEDENT CAUSE(S) DUE TO (B) Sarcoma of rt. leg with metastasis						9 mo.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) metastasis							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 2 19 61 , to Nov. 19 19 61 , that I last saw the deceased alive on Nov. 19 19 61 , and that death occurred at 11:35 A.M. from the causes and on the date stated above.							
SIGNATURE Ralph Culandella				ADDRESS (Street, city, town, state) Kitzmiller, Md.		DATE SIGNED Nov. 20-61	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Nov. 21/61		NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery		LOCATION (City, town, or county) (State) Elk Garden, W. Va.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Kenneth E. Thomas		25. FUNERAL DIRECTOR'S SIGNATURE Amy M. Sharpless		ADDRESS Blaine, W. Va.	
DATE NOV 22 '61							

MEMORIAL

There is a special law in Maryland which requires that all deaths be reported to the State Department of Health. It is the duty of every citizen to report the death of a person to the local health officer. This report is made on a form which is filled out by the family or the person who has charge of the body. The form is then sent to the local health officer, who will forward it to the State Department of Health. The State Department of Health will then issue a death certificate. This certificate is a legal document which is used to prove that a person has died. It is also used to determine the cause of death. The death certificate is a very important document, and it is the duty of every citizen to make sure that it is filled out correctly. If you are the family or the person who has charge of the body, you should fill out the form as soon as possible. If you are not the family or the person who has charge of the body, you should let the family or the person who has charge of the body fill out the form. The form is a simple one, and it should not take much time to fill out. It is a very important document, and it is the duty of every citizen to make sure that it is filled out correctly. If you are the family or the person who has charge of the body, you should fill out the form as soon as possible. If you are not the family or the person who has charge of the body, you should let the family or the person who has charge of the body fill out the form. The form is a simple one, and it should not take much time to fill out. It is a very important document, and it is the duty of every citizen to make sure that it is filled out correctly.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. PLACE OF DEATH	
3. SEX		4. AGE	
5. DATE OF BIRTH		6. DATE OF DEATH	
7. TIME OF DEATH		8. PLACE OF BIRTH	
9. OCCUPATION		10. CAUSE OF DEATH	
11. MANNER OF DEATH		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF PHYSICIAN	
15. SIGNATURE OF CLERK		16. SIGNATURE OF JUDGE	
17. SIGNATURE OF SHERIFF		18. SIGNATURE OF CORONER	
19. SIGNATURE OF JURY		20. SIGNATURE OF COURT	
21. SIGNATURE OF STATE DEPARTMENT OF HEALTH		22. SIGNATURE OF LOCAL HEALTH OFFICER	
23. SIGNATURE OF COUNTY CLERK		24. SIGNATURE OF COUNTY JUDGE	
25. SIGNATURE OF COUNTY SHERIFF		26. SIGNATURE OF COUNTY CORONER	
27. SIGNATURE OF COUNTY JURY		28. SIGNATURE OF COUNTY COURT	
29. SIGNATURE OF STATE DEPARTMENT OF HEALTH		30. SIGNATURE OF LOCAL HEALTH OFFICER	
31. SIGNATURE OF COUNTY CLERK		32. SIGNATURE OF COUNTY JUDGE	
33. SIGNATURE OF COUNTY SHERIFF		34. SIGNATURE OF COUNTY CORONER	
35. SIGNATURE OF COUNTY JURY		36. SIGNATURE OF COUNTY COURT	
37. SIGNATURE OF STATE DEPARTMENT OF HEALTH		38. SIGNATURE OF LOCAL HEALTH OFFICER	
39. SIGNATURE OF COUNTY CLERK		40. SIGNATURE OF COUNTY JUDGE	
41. SIGNATURE OF COUNTY SHERIFF		42. SIGNATURE OF COUNTY CORONER	
43. SIGNATURE OF COUNTY JURY		44. SIGNATURE OF COUNTY COURT	
45. SIGNATURE OF STATE DEPARTMENT OF HEALTH		46. SIGNATURE OF LOCAL HEALTH OFFICER	
47. SIGNATURE OF COUNTY CLERK		48. SIGNATURE OF COUNTY JUDGE	
49. SIGNATURE OF COUNTY SHERIFF		50. SIGNATURE OF COUNTY CORONER	
51. SIGNATURE OF COUNTY JURY		52. SIGNATURE OF COUNTY COURT	
53. SIGNATURE OF STATE DEPARTMENT OF HEALTH		54. SIGNATURE OF LOCAL HEALTH OFFICER	
55. SIGNATURE OF COUNTY CLERK		56. SIGNATURE OF COUNTY JUDGE	
57. SIGNATURE OF COUNTY SHERIFF		58. SIGNATURE OF COUNTY CORONER	
59. SIGNATURE OF COUNTY JURY		60. SIGNATURE OF COUNTY COURT	
61. SIGNATURE OF STATE DEPARTMENT OF HEALTH		62. SIGNATURE OF LOCAL HEALTH OFFICER	
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77. SIGNATURE OF STATE DEPARTMENT OF HEALTH		78. SIGNATURE OF LOCAL HEALTH OFFICER	
79. SIGNATURE OF COUNTY CLERK		80. SIGNATURE OF COUNTY JUDGE	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12664

12652

1. PLACE OF DEATH e. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE W. V. A. b. COUNTY PRESTON	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) AURORA	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS 85X-3	
3. NAME OF DECEASED (Type or print) First Middle Last LILLIE FLORENCE STEMPLE		4. DATE OF DEATH Month Day Year NOVEMBER 18 19 61	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 4, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 83 yrs. IF UNDER 1 YEAR: Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) AURORA, WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME KING WOTRING		14. MOTHER'S NAME LAURA HARSH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		17. INFORMANT Address Frank Stemple Aurora, W. Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic (terminal) pneumonia 4 22-1 DUE TO (b) Arterio-sclerotic Cardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Discrete PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 18 hours 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JAN. 18, 1957, to NOV. 18, 1961, that (I) (we) last saw the deceased alive on NOV. 18, 1961, and that death occurred at 1:35 A.M., from the causes and on the date stated above.			
22a. SIGNATURE A. E. Mance		22b. DATE 18 Nov 61	
22c. PHYSICIAN'S NAME (Type) DR. A. E. MANCE		22d. ADDRESS OAKLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/20/61	23c. NAME OF CEMETERY OR CREMATORY Aurora	23d. LOCATION (City, town or county) (State) Aurora W. Va.
24 FUNERAL DIRECTOR'S SIGNATURE Wayne C. Spiggle		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE NOV 22 '61 Arthur S. Farris	

12552

12552



RECEIVED

W. V. A.

RECEIVED

AMERICA

7 DAYS

CALIFORNIA

RECEIVED WHITE MEMORIAL HOSPITAL

13

NOVEMBER 13

31

FLORNOY

WALSH

13

APRIL 1, 1978

WALSH

RECEIVED

AMERICA, WEST VIRGINIA

Housewife

LAUREN MARCH

RECEIVED

AMERICA, W. Va.

Front Stangle

[Faint, illegible handwritten text]

1978, 12/13, 1978, 12/13

NOV. 13, 1978

RECEIVED

AMERICA

RECEIVED

W. Va.

AMERICA

AMERICA

11/30/78

RECEIVED

Lavis, W. Va.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

12665

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12653

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hutton		c. LENGTH OF STAY IN 1b 41 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John First Wesley Middle White Last		4. DATE OF DEATH 11 Month 10 Day 1961 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 25, 1870
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Gorman, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John White		14. MOTHER'S MAIDEN NAME Eliza Moon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Roy White Address Rural Hutton, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pernicious Anemia 290.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 18 years 15 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/1/1948 to 11/10/1961 that (I) (we) last saw the deceased alive on 11/3/1961 , and that death occurred at 3:35 a.m. from the causes and on the date stated above.			
22a. SIGNATURE Andrew E. Mance		22b. DATE SIGNED 11 Nov 61	
22c. PHYSICIAN'S NAME (Type) Andrew E. Mance		22d. ADDRESS 3 rd St. Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/12/61	
23c. NAME OF CEMETERY OR CREMATORY Terra Alta Cemetery		23d. LOCATION (City, town, or county) (State) Terra Alta W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minnich		25a. REC'D BY REGISTRAR NOV 13 '61	
ADDRESS Oakland, Maryland		25b. REGISTRAR'S SIGNATURE Arthur E. Harris	

13661

CENTRAL OF GEORGIA

1-2-23



Richard H. Moore

CLIP TEN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12666

CERTIFICATE OF DEATH

12654

1. PLACE OF DEATH a. COUNTY GARRETT COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY HORSE SHOE RUN			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OAKLAND, MARYLAND				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HORSE SHOE RUN			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS 85X-3			
3. NAME OF DECEASED (Type or print) LAURA ELIZZBETH WHITEHAIR				4. DATE OF DEATH Month 11 Day 3 Year 1961			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/2/1900	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 11 Days 3		IF UNDER 24 HRS. Hours 19 Min. 61			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA				12. CITIZEN OF WHAT COUNTRY? UNITED STATES			
13. FATHER'S NAME SLAUBAUCH, ELI				14. MOTHER'S MAIDEN NAME REMBOLD, MARY CHRISTINA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT OSCAR WHITEHAIR, HORSE SHOE RUN, W. VA.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (b) Myeloid cystitis (a), stating the underlying cause last. (c) Cardiomyopathy paraneoplastic				INTERVAL BETWEEN ONSET AND DEATH 10 days 20 hrs 1 yr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-3 , 1961 , that (I) (we) last saw the deceased alive on 10-25 , and that death occurred at 10-25 , from the causes and on the date stated above.							
22a. SIGNATURE A. E. Mance				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/2/61	
22c. PHYSICIAN'S NAME (Type) Dr. A. E. Mance				22d. ADDRESS OAKLAND, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/5/61		23c. NAME OF CEMETERY OR CREMATORY Texas		23d. LOCATION (City, town or county) (State) Horse Shoe Run W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Spizzle				ADDRESS W. Va.		25a. REC'D BY REGISTRAR NOV 13 '61	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kneas	

15866

15866

(M)

(1)

Horse Shoe Run W. Va.

Texas

11/5/51

Bureau

W. Va.

Davis

W. Va.

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12667

12655

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland			c. LENGTH OF STAY IN 1b 12 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frances Middle Zelphia Last Wilson				4. DATE OF DEATH Month Nov. Day 5 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 16, 1892		9. AGE (In years lost birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Elk Garden, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Paugh				14. MOTHER'S MAIDEN NAME Rosealee Copelind			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Edward S. Wilson Address Oakland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis ducts 199 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma RT Ear DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 8 mos 2 yrs						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/21/61 to 11/5/61 that (I) (we) lost saw the deceased alive on 11/4/61 and that death occurred at 6:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Andrew E. Mance				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/20/61	
22c. PHYSICIAN'S NAME (Type) Andrew E. Mance				22d. ADDRESS 3rd St. Oakland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/8/61		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION (City, town, or county) (State) Garrett Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minnich				ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR DATE NOV 13 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. House			

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1920

CERTIFICATE OF DEATH

1920

(M)

Blank form with faint lines for text entry, including fields for name, date, and cause of death.